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ABSTRACT

Basic knowledge and practice skills in assessment and interview techniques for the beginning level child welfare worker are provided in this self-instructional manual. The material is geared specifically to the worker in abuse and neglect or foster care cases. In Part 1 of the guide, the areas of intake and assessment are considered. The intake process is described, basics of intake and assessment are enumerated, an assessment outline is provided, and forms for recording intake data and for evaluating the child's relationship with adults and peers are given. Early diagnosis of the severity of abuse is presented as a tool in case management, and types of physical abuse cases referred to protective service agencies are described. Issues regarding removal of children from the home are addressed. Interviewing is discussed in Part 2 of the manual. Worker self-awareness questions are provided and worker behaviors which may invite or discourage attack are listed. Suggestions are made for dealing with hostility. Basic directive and non-directive interviewing techniques are explained and flexible guidelines for interviewing and working with children are described. Interviewing and practice techniques are included. Lists of training materials and references for assessment and interviewing are given. (NRB)

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ASSESSMENT AND INTERVIEWING IN CHILD WELFARE

Cynthia Christy-Baker, MSW
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TULANE UNIVERSITY SCHOOL OF SOCIAL WORK
NEW ORLEANS, LOUISIANA

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By

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INTRODUCTION

This material was developed to provide the beginning level child welfare worker with basic knowledge and practice skills in assessment and interviewing. It was designed to be used individually for self instruction. The material may also be used for staff training in groups. Many of the current textbooks on interviewing and assessment provide an excellent background for use in social work interviewing. However, thay are often geared to psychiatric interviewing or casework with the voluntary client. Many of the clients who enter the public child welfare system are not voluntarily involved in the system. This material is geared specifically to the child welfare worker in abuse and neglect or foster care. This material is not intended to replace routine training in the child welfare agency but may be used with new workers as a basic guide for beginning investigations, assessments, and basic helping interviews.

Workers who would like to pursue this topic in depth should refer to the resource material located at the end of this document.

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PART I
INTAKE AND ASSESSMENT

THE INTAKE PROCESS
Some Considerations

What is the purpose?

There is always a phase of fact gathering appropriate to the problem and request initially presented. This must be done even in the 1st interview to help the person define the service he is asking to determine if this is the agency that can meet the request.

Recognition of the client's own attempts at solution is important as well as discussion of his future plans, encouragement toward self-sufficiency, and the maintenance of his potential strength and energy. In a crisis-oriented approach, it is important to focus quite directly around the crisis situation and relate the presentation of facts directly around this.

In Intake, we notice and accept, rather than explore in depth the client's feelings; initiate a working, not an intensive relationship; clarify the situation; make sure this is the agency for his problem or determine where a referral can be made; find out what the person has done about his problem, and what he wants to do or wants us to do regarding it; give him some ideas of what the service offered through the agency can be; the expectations of him as well as what he can expect of us.

How do we focus?

We focus through the request - what the applicant wants to do, what the agency or law requires us to do. Hence, we meet at the point of greater interest or need.

The caseworker must enable the person to verbalize his request and express his preconceptions about the helping process to which he is addressing himself. We explore around the complaint. Getting the relevant facts tends to establish the relationship. However, it is clear that the treatment process brings immediately and advances simultaneously, even as an exploration of the problem and accompanying factors are still in the force.

How do we assess the applicant?

An assessment of the person's ability to use help may be related to how he presents himself, his willingness to discuss the reality, the logic and coherence of his presentation, his responses to the questions which are raised in an attempt to understand his request or meet agency requirements. Part of the treatment objective is greater acceptance by the client of his "real self."

On attempt to give appropriate recognition and reassurance to the client's efforts in meeting his problem, but it is not recommended that all guilt and discomfort be removed at the outset. Some discomfort and even guilt about the problem can become the moving forces in helping the client to involve himself in treatment and move toward a solution.

Some questions appropriate to the intake and assessment process:

- What is the matter -- what is it the person needs and wants to be rid of or take hold of?
- What does the problem mean to or do to the person who has it -- how does it affect his physical, emotional, and social welfare?

- What causes the problem or brings it about?
- What has the person thought of and tried to do about it?
- How long has this person seen this problem as a problem?
- What does the person expect of us? Are his expectations realistic?
- Why does he seek help now? Did the client seek help, was he referred, was a complaint filed.
- Does the person see the situation as a problem?

INTAKE DATA

(WHO) Identifying Information:

(WHAT) Presenting Complaint:

(WHEN) Precipitating Events and Etiology of Problems:

(WHERE) Social Situation and Relationships:

(HOW) Assessment, Diagnosis, Recommendations:

INTAKE AND ASSESSMENT

I. Intake

A. Identify the problem
1. What brought the client to the agency
2. How does the problem affect the daily functioning of the individual and his/her family
3. When did the problem begin
4. What efforts has the client made to cope with the problem
5. Has the client sought help currently or in the past
6. What person(s) did the client utilize for helping in understanding or resolving the problem (parent, friend, neighbor, immediate family member, professional, etc.)
7. Has the client previously used professional help (for how long, basic results, reason for seeking help)
8. What led to the client seeking help now - precipitating event
9. What symptoms does the client identify currently historically
10. Who are the people involved with the problem as identified by the client and others
11. How does the core problem relate to secondary problems

B. Evaluate the person
1. What hopes and aspirations are present
2. What motivated the client to seek service (voluntary, court ordered)
3. What does the client expect from your agency (outcome)
4. What is the level of discomfort experienced by the client
5. Evaluate the ability of the client to deal with the problem: how does the client perceive the problem; what strengths and weaknesses are present; how does the client cope in general; what capacity does the client show for involvement with the worker or participation in the working process.
6. What strengths or weaknesses are present in the total environment that influence the situation and the client (housing, financial stability, network of family resources, friends or neighbors, community systems such as church or other organized activity.
7. Evaluate the social and psychological components of the situation: What are the basic presenting aspects of the clients' personality (evidence of strengths and weaknesses); what are the clients' life motivations; capacity to achieve and opportunity available for success or failure.
8. What ability does the individual or family show to engage with the worker and utilize services.

C. Assessment of basic case plan agreement (contracting)
1. How do the goals set relate to identified problems
2. What immediate steps were agreed on - by the worker; by the client
3. What is the timeframe for completion of work - 1 week, 1 month, 1 year, etc., share with the client
4. What are the short range goals
What are the long range goals
List and share then, be willing to negotiate differences with the client.
5. Clarify goals/requirements of the agency

BRIEF ASSESSMENT OUTLINE

I. BACKGROUND INFORMATION

A. Description of clients, including social worker's general reactions
B. Identifying information and problem classification (age, sex, social class, marital status, religion, physical living situation)

II. PROBLEMS

A. What are the problems in social functioning with which the client needs help? (As seen by worker-client.)
B. How did the problem originate or develop? What caused it?
C. How does the problem affect the social functioning of individuals, family group or other significant persons? (Summarize the current functioning of individuals or family and client's perception of the problem)

III. MOTIVATION

A. What evidence is there of client's readiness to work on problem and use agency help?
B. What resistances can be anticipated?
C. Diagnostic evaluation of client's family capacity for improved functioning in areas of difficulty.
    1. Family Diagnosis
        a. Family functioning within their particular social and cultural groups within larger community.
        b. How does family function internally as a small group?
            1. Relationships. (Marital, parent-child, sibling)
            2. Roles. (Reciprocity, complimentary, reversals, etc.)
            3. Family balance and stability.
        c. How does family functioning contribute to problem areas? Define causative factors in both past and present if indicated.
        d. How does the social situation affect family functioning in problem areas?
        e. How does family functioning support or limit possibilities for change? (Strengths and weaknesses.)
    2. In individuals with whom agency will work:
        a. Physical and intellectual functioning. How do they appear to measure up to norms? Note speical problems, handicaps, capacities.
        b. Social functioning:
            1. How does he function in his various social roles?
            2. Main areas of functioning.
            3. Social factors relating to problems in social functioning.
        c. Personal integration:
            1. Ego functioning (strengths and weakness):
            (Nature of self image, quality of object relatedness, quality of perception, quality of reality testing and adaptation, capacity to cope with life stresses, patterns of control and frustrations--capacity for self control, flexibility, etc., memory and judgement, ego defenses and adaptive patterns, degree of psychic energy).

2. Quality of impulses (amount of ambivalence, quality of agression, attitudes toward opposite sex, etc.)
3. Quality of super-ego (standards, are they normal for the cultural severity, rigidity, consistency, etc.)

d. Define causative factors in the problem in both past and present if indicated, indicating the interaction between physical, emotional and external stress components for the individual.

IV. ASSESSMENT SUMMARY

V. TREATMENT PLAN: (short and long term--individual and/or family)

EVALUATING THE CHILD'S RELATIONSHIP WITH ADULTS AND PEERS

Contact with adults

The following is a check list of items that can be observed in the child's daily routines such as school, activity with siblings, formal and casual contact with adults, etc.

1. Does the child make contact with the adult and in what situation?

   How frequently does the child seek contact?

   Does the child:

   - come for approval _____
   - seek attention _____
   - give or get affection _____
   - express anger or hostility _____
   - request help with conflict _____
   - involve the adult with play or work materials and ideas _____

2. What is the quality of the child's contact with adults?

   - Trusting _____
   - Timid _____
   - Belligerent _____
   - Clinging _____
   - Openly hostile _____
   - Markedly withdrawn _____
   - Matter-of-fact _____
   - Reserved _____
   - Whining _____
   - Demanding _____
   - Warmhearted _____

3. How does the chili gain attention?

   - Excessive talking _____
   - Shows off personal items such as toys, clothes, etc. _____
   - Tattling
   - Sharing information about his/her family _____
   - Touching or reaching out _____

4. How does the child react to adults?

   When:

   Affection is offered

   - accepts _____
   - returns _____
   - squirms _____
   - stiffens up _____
   - pushes away _____

Suggestions are offered
- follows through reluctantly _____
- ignores _____
- avoids _____
- accepts and gives thanks _____
- discusses questions _____

When help is offered
- accepts _____
- becomes clingly and dependent _____
- rejects _____
- becomes interested _____
- becomes angry _____

5. How does the child respond in situation where adult authority may be controlling, setting limits and/or curtailing child from total freedom of movement. When limits or restrictions are given such as denial of permission or group rules.
   - accepts with no emotional investment _____
   - defies openly _____
   - cries or withdraws _____
   - resists passively by lingering _____
   - accepts but verbalizes the reason or mimics by repeating _____
   - continues at previous task in which he is involved _____

   When criticism is given the child:
   - cries _____
   - pouts _____
   - accepts _____
   - questions _____
   - sulks _____
   - becomes belligerent _____
   - withdraws _____

6. How does the child react to sharing the adult with other children or other adults?
   - ignores _____
   - interrupts and demands attention _____
   - has tantrums _____
   - waits for adults to return to him _____
   - accepts easily _____
   - waits without resentment _____
   - cries _____
   - sulks _____

How the child handles relationships with adults will provide information for assessment:

- dependency on adults
- rejection of adults
- ability to meet adults on equal terms, to accept or reject overtures as appropriate
- ability to handle authority without conflict or being overly passive
- evidence of independence from adults or dependence on adults

It is always important to keep the age of the child in mind. The dependency needs of a 2 or 3 year old should be different from those of a 6 or 8 year old. These observations may give an excellent assessment of the child's emotional age as compared to the chronologic age.

The child who has been abused will present several of the following characteristics with adults:

- wary of adult contacts
- frightened of parents or other adults
- fearful of returning home
- withdrawn
- overcompliant in all situations
- stiffens when affection offered
- overly independent
- cries easily

Contact with Peers

The following is a list of observations of how the child interacts with other children.

1. Is the child interested in other children?
   - number of children played with _____
   - request for help in entering the play situation _____
   - watching others play _____
   - imitating or attempting to attract attention of others _____

2. Does the child move towards others _____
   or against them? _____
   - timidly _____
   - pleadingly _____
   - aggressively _____

3. How do others interact with the child?
   - includes in play _____
   - avoids _____
   - withdraws from _____

4. How does he react to the behavior of others?

criticism	_____
suggestions and ideas	_____
aggressions	_____
invitations to play	_____

5. What are the child's feelings toward other children and how does he/she fit in relation to the total group?

likes others	_____
envies	_____
fears	_____
plays with both sexes	_____
plays with only opposite sex	_____
plays with same sex	_____
accepted by group	_____
plays alone	_____
plays with same child all the time	_____
has a best friend	_____
allows others to enter play group	_____

It is important in observing children's play that age appropriateness is included as a part of the assessment. The child of 3 may play with a toy alone and not include others. However a child of 8 would have problems if others were not included in play activities. It is important to observe special problems or trends that might be present such as:

impatience with others
allowing exploitation by others
excessive hitting, biting or other aggressive behavior
excessive dependence on adults
difficulty with speech or other communication problems

The child who has been abused, neglected or emotionally maltreated may exhibit:

behavioral extremes of aggression or withdrawal
constant fatigue and noninvolvement with other children
antisocial behavior
compulsions, phobias
overly adaptive and compliant

The sexually abused child or adolescent will display

unwillingness to change for gym or participate in physical education
withdrawal, fantasy or infantile behavior
poor peer relationships
delinquent or run away behavior

Children vary in how they handle relationships with adults and peers. It is important to establish a history of how the child handled relationships before attempting to make a final assessment.

DIAGNOSING THE SEVERITY OF PHYSICAL ABUSE AS A CASE MANAGEMENT TOOL IN PROTECTIVE SERVICES*

Many disciplines are involved in theproblem of child abuse; professional literature abound in material regarding diagnosis and treatment. One discipline that has a major responsibility is public protective services. In most states the public agency is mandated by law to investigate and make dispositions of child abuse cases, seek legal custody of the child if necessary, provide foster care services, provide counseling for parents and children maintain children in their own homes when possible, reunite families, or provide for adoptive placements. The protective service worker is often faced with critical decisions without benefit of other disciplines input and with incomplete information. He wants to avoid unnecessary child placement but he does not want a child to remain in an environment where the child may be further injured or killed.

If one examines the case records of protective service agencies certain distinct patterns of abuse cases appear. The patterns form four major clusterings; excessive physical punishment, excessive physical punishment accompanied by emotional abuse, child battering, and sadistic/psychotic forms of abuse created by the pathology of the parent. In the first group the child can safely remain at home while services are provided. The second group of children may need placement but also need intense esteem building services. The battered children often need to be removed temporarily but the vast majority can return home safely. The last group of children must be removed and never returned due to the extreme danger their parent's illnesses present. While the boundaries of the four groups are not completely clear-cut, certain characteristics emerge during the initial phase of protective service involvement. By utilizing these characteristics as the basis for a diagnostic model, the worker can determine the nature and severity of the case situation and utilize its prognosis as a tool in ultimate case management.

EXCESSIVE PHYSICAL PUNISHMENT:

In a society where physical punishment of children is considered an appropriate method of discipline, it is little wonder that some parents adhere to this practice so rigidly that the family is referred to a protective services agency. Certain elements are usually present in cases of this nature.

(1) The child must be old enough to understand parental expectations of him; punishment is the result of the child's misbehavior.

Typical incidents of excessive physical punishment involve school aged children. The child has engaged in a forbidden activity such as stealing, lying, keeping late hours, etc. The behavior is one that would be considered unacceptable in most families. Parental expectations of the child are realistic as contrasted to the battering parents' unrealistic expectations. The child frequently mini-

* This material was developed by Carole W. Bowdry, MSSW for the Basic Job Skills Training Child Welfare Services: Trainees Coursebook. Texas Department of Human Resources Protective Services for Children Branch and Staff Development Division of Personnel Service.

mizes his own role in the situation.

> Jane, a 13 year old girl, was referred for protective services after a severe whipping by her mother. She had numerous linear bruises on her upper back, buttocks, and thighs. Jane told the caseworker that her mother had whipped her with a belt for getting a bad grade in school. When the mother was interviewed she readily admitted whipping Jane becasue the girl had stolen some money from the mother's purse. This was not the first episode of Jane's stealing. The mother expressed fears that her daughter might become delinquent if the behavior continued.

(2) The parents perceive physical punishment as an appropriate means of dealing with misbehavior, they do not perceive themselves as abusive, but exercising parental responsibilities.

The parent who utilizes excessive physical punishment usually reveals a similar history in his own childhood. He sees his parents method of discipline as the reason he has become a "good citizen."

The parent readily admits to whipping the child and appears shocked that anyone could perceive his actions as inappropriate. He usually states that whipping is the only method of punishment that gets results. He may admit that the whipping was too severe, but he maintains his parental prerogative to discipline his child. His justification for his behavior is that he is deterring the child from acts that could lead to criminal behavior. He does not see himself as an abusive parent and is genuinely amazed that his behavior has precipitated a referral to a protective services agency.

> Mr. N. was referred for protective services after severely whipping his 8 and 10 year old sons. The boys had engaged in some minor vandalism at the school. Mr. N. was quite hostile toward the worker saying if he didn't correct his children they would end up as criminals. He expressed his belief that his father's discipline had kept him from getting in trouble. After he had ventilated his anger at agency intervention, he soberly expressed remorse that the whipping had been severe. He shared his concern that the boys had been in much trouble at home and at school. He was genuinely worried that their current behavior would lead to more serious acts. He asked help in dealing with his boys. Upon leaving the agency he observed a 2-year old child who had been brought by the police. He was quite shocked and dismayed saying, "Who could hurt a little child like that?"

(3) Injuries are not serious in nature.

Injuries that are the result of excessive physical punishment are limited to bruises, cuts, and welts received as the result of a vigorous whipping. The parent frequently uses belts, paddles, switches, or extension cords. The marks may predominate on the buttocks and thighs but will often appear on the upper back. It is important to remember that injuries of this nature are serious when inflicted on very young children and infants.

(4) Parents may be quite angry with the child and express many difficulties in managing him, but no bizarre thinking about him is present.

The parent who utilizes corporal punishment generally does so with all the children in the family. While the parent may lost control and whip the child far more severly than he intended, he does not attribute to the child evil intentions or project his own inadequacies onto the child.

While intervention is certainly needed into these family systems, the children are not at risk of being killed or seriously injured. Damage to the child may be further intensified by removal and placement in foster care. The child often sees himself as being punished by taking him from his family setting and the parents may tend to see the placement as the agency's taking over to correct the child's problem behavior. Change is most successfully effected if the family system is treated as a whole and while it remains intact. The worker needs to convey a sincere interest in the parents, support in their caring and their concern for their children, information regarding child development and child behavior, alternate methods of discipline, and new ways of coping with family stress.

The child needs to learn his parents' expectations of him, to develop more positive means of getting his parents attention, to recognize his limits, and to take responsibility for his behavior.

EXCESSIVE PHYSICAL PUNISHMENT ACCOMPANIED BY EMOTIONAL ABUSE:

Some children may be referred for visible injuries when physical abuse is minor in relation to the emotional abuse the child is suffering. The child is the classic scapegoat; he is held responsible for all the problems the family has and receives no positive feedback for any achievements. He is related to by family members in such a way that his feelings of selfworth are destroyed. Other children in the family receive parental affection while the emotionally abused child receives none. The child begins to perceive himself as a worthless misfit who has no entitlement to joy and love.

> Sandra, a pretty 12 year old was referred for protective services by the school after she had received a severe whipping by her father. As the caseworker became involved sith the family she learned that Sandra's stepmother refused to let the child eat with the other family members, referred to the child as "it." drove the other children to the school Sandra attended but refused to let Sandra ride in the car, and had on occasion forced the child to sleep in the garage due to her enuresis. Not until her caseworker removed her from her home was Sandra able to express any anger at her maltreatment.

It is unfortunate that most of these children receive no protection until the abuse they receive becomes physically visible. They frequently live out their desolate childhoods unobserved by the community and unrecognized by the Juvenile Court. It is difficult and frustrating for protective service workers to establish adequate evidence for removal of these children by the legal system. Photographs can be taken of bruises on the body, but it is almost impossible to document bruises on the soul. As a result much of the caseworker's early efforts are directed toward treatment of the family as a unit. If family roles are so rigidly defined that change cannot take place, the most viable alternative for the child is placement outside the home. If a suitable

relative resource can be found for the child, it is usually preferable as placement is generally permanent in nature. Often these children are not discovered until their preadolescence. They are often so damaged that they have difficulty being maintained in foster homes. The series of placements they often encounter serves to further reinforce the rejection of the natural home.

It is of vital importance that the child who is the victim of emotional abuse receive therapeutic services to build self esteem. A nurturing, caring relationship may be the single most meaningful intervention in the child's life whether he remains in his own home or enters other placement.

CHILD BATTERING:

Although some older children can be considered victims of child battering, the vast majority of battered children referred for protective services are quite young. Due to the child's lack of mobility and his lesser visibility in the community, the young child is at great risk of further injury should his plight go unrecognized.

While a medical diagnosis is of major importance, certain critical factors need to be explored by the protective service worker for diagnostic and treatment purposes. It is necessary to explore these factors whenever a young child receives an injury that is unexplained or poorly explained by the parents.

1. HISTORY OF PREVIOUS ABUSE:

Many children present evidence of previous injury at the time of referral. Old scars and fading bruises are visible to the caseworker. It is also essential that at radiological survey be made to determine if old fractures and evidence of previous trauma are present. While this evidence must be evaluated by medical personnel, other historical factors are appropriately pursued by the caseworker.

The worker should determine from interviewing the parents whether there has been a history of other children in the family who have received injuries or if another child has died. If the history is positive, the worker should attempt to obtain medical records to establish the kinds of injuries received or the cause of death. It is important to note that in many unsophisticated communities, the diagnosis of child abuse as the cause of death is frequently not made. The death is attributed to accidental causes or sudden infant death syndrome even when evidence of child abuse in overwhelming.

> Lisa L., 3 years old was referred for protective services after neighbors noted several bruises on her hips and thighs. Although the caseworker noted many elements of child battering potential in the family dynamics, there was insufficient evidence to obtain a court order. During the process of investigation, the family moved out of state. Within six weeks the child was dead. The out-of-state medical examined ruled accidental death. When the body was returned for burial to the former community, a court order

was obtained to examine the body as there were other young children in the family. When the body was examined it was noted that it was covered with bruises typical of child abuse. The other children were removed, quite fortunatley, for it was learned that Lisa's 4 year old brother was witness to the beating death of his sister by his mother's boy friend. Neighbors later told of observing bruises on this little boy, also, in the past.

A positive history of relatives' referral for child abuse is not uncommon. Child abuse stems from family environments producing low self esteem and providing inadequate nurturing. The children reared in these families may become abusive when they are parents, or permit their partners to be abusive to the children.

When Mrs. L.'s 2 year old son was referred for protective services after a severe battering by his stepfather, Mrs. L revealed to the caseworker that her sister's child had died of suspected child abuse. Since the sister, Mrs. M., was once again pregnant, preventive services were extended to her as well. Soon after the birth of the child, he was battered by his father. Both sisters had formed relationships with men who severely abused their children.

During the process of investigation it is often learned that one of the caretakers has previous involvemnt with child abuse in the same or a different family constellation. The role taken may be that of active abuser or passive abuser. The parent may reveal that an ex-husband has abused one of the children in the past. A new stepfather may mention that he was accused of child abuse in another state or city, involving a previous family.

The state of Texas has developed a computerized reporting and inquiry system for child abuse and neglect. This system, called CANRIS, is invaluable in determining prior involvement of any member of the household in abuse or neglect throughout the state. A worker can have this information available to him in the very earliest stages of the investigation. If such a system could be developed on a national level, there is little doubt that more children could be protected from further injuries and death. Until such a system is implemented it is imperative that protective service workers explore history given by parents of previous incidents of abuse with appropriate authorities in other communities.

2. PSYCHO-SOCIAL CHARACTERISTICS OF BATTERING PARENTS

It appears superfluous to discuss characteristics of abusive parents, since so much has already been written about them. Most professionals have familiarized themselves with the excellent material developed and reported by Dr. Henry Kempe and Ray Helfer. Protective service workers can describe the characteristics defined in the literature but often have difficulty in translating the theoretical base into their day-to-day practice. Since this material is written by and for an average protective service worker, practical matters in diagnosis will be addressed.

Abusive parents typically present a history of a childhood characterized by a lack of nurturing. Physical abuse, sexual abuse, and neglect may be pre-

sent. The feeling of being unwanted and unloved is a common theme in the background of the abusive parent. These feelings are so painful for the person that he frequently denies them in the early stages of treatment. This denial is not surprising when considered in the context of the parent's experience of rejection when he has attempted to share his joy and pain.

The parent may reveal a history of placement outside his home. This placement may have been with relatives, in foster homes, institutions for the dependent and englected, or institutions for delinquent children. The issue is that placement may have been due to a distrubance in family or parent-child interactions which reflects the lack of nurturing.

The parent is overwhelmed by feelings of inadequacy and worhtlessness. Since he has never develeped basic trust due to his early experiences, it is difficult for him to form relationships with others. The parent may share his feelings of being different from his siblings and compare himself negatively to them. He may discuss concerns that something is wrong with him.

> Mrs. L. told her caseworker that she had always thought something was wrong with her but she had "pretended to be a normal, walking around person."

The low self esteem contributes to the isolation of the parent. The parent has few friends and little social activity. Marital relationships tend to be shallow and immature. The couple may engage in a clinging, dependent relationship with each other but lack skill in solving problems. Conflict is never resolved productively.

The abusive parent has very unrealistic expectations of his child. The parent wants the child to love and nurture him. When the child is unable to provide his parent with the desired affection, the parent perceives this behavior as another attack on him and his adequacies.

The parent attributes feelings and understanding to the child far beyond the child's capability. Knowledge of child development is limited. Premature expectations for the child's achievement of developmental milestones appear linked to the parent's need to be perceived as a good parent. An infant's crying or a toddler's wetting or soiling is considered to be a rebuke and a rejection of the parent.

> An 18 year old mother, visiting with her 2 month old son who was placed in foster care, commented, "Look how mad he is at me. I can tell by the expression on his face."

3. In the vast majority of families where child abuse occurs, two adults are present on at least a part time basis. Very rarely do both adults actively abuse the children; one is the active abuser while the other permits or at times encourages the abuse. It is extremely important that protective service workers fully understand this configuration if they are to prevent recidivism of abuse. All too often, children are reinjured because the worker assumed the child was safe since the abuser was out of the home. Adults need other adults. The passive abuser permits reentry of the active abuser who has left untreated, selects another companion who is also abusive,

or becomes actively abusive herself.

Passive abusers present essentially the same psycho-social characteristics as active batterers. Low self-esteem, lack of nurturing dependency, and unrealistic expectations of the child are consistent. Many young mothers who permit their husbands or paramours to batter their children reveal a history of incest in their backgrounds. The passive abuser believes herself to be worthless and undeserving; the attitude about self is carried over to the child. If the active abuser meets the passive one's needs, she is able to tolerate maltreatment of the child in order to maintain the relationship.

> Susan, a pretty 19 year old, was interviewed by a caseworker after her 8 month old son was beaten to death by her boyfriend. She stated, "He told me never to leave Jimmy alone with him and I knew Jimmy kept getting funny brusises. But Joe is the only person who ever made me feel like somebody; he's the only person who ever cared about me."

The passive abuser engages in denial during the process of the abuse, so that the relationship with the active abuser can be maintained. Injuries to the child are accepted to be the result of accidents if they occur outside the passive partner's presence. If the passive abuser witnesses the abuse or is told about it, she minimizes the injuries and verbalizes her belief that abuse will not recur.

In some instances, this denial manifests a quality of subtle permission; the child is left alone repeatedly with the abuser to be injured again and again. At other times, the encouragement seems more overt. The passive abuser sees the active abuser as a means of controlling and disciplining the child. The acts of abuse are justified by the passive partner as necessary to prevent or correct misbehavior.

In light of the need of the passive abuser for the active abuser emotionally or an an instrument to act out aggressive feelings toward the child, it is totally unrealistic for protective service workers to insist, or for Juvenile Court systems to order a termination of the relationship between the adults. An external system's decreeing that a relation cease is completely ineffective when the two individuals invested in the relationship do not desire its termination. In attempting to force the parent to choose between the spouse/lover and the child, it is essentail to realize that the choice has already been made when the child has suffered repeated injuries.

Even if one relationship with an active abuser terminates, the passive abuser seems to have a penchant for selecting another abusive partner. Child welfare case records are full of examples of children who have been abused by a progression of individuals who have come into their homes. This all too commcn phenomemon bears out the need the passive abuser has for another person to act out aggression on the child. Without the presence of an active abuser, the passive partner may begin to take out her frustratiosn overtly on the child.

It is critical that the passive abuser receive treatment if future abuse is to be prevented. The passive abuser needs to examine his or her role and take responsibility for the actions that enabled the abuse to occur. Since the person

has generally seen herself as a "helpless victim" who has no control over her life and circumstances, it is imperative the worker help the client to examine the part she plays in becoming the "victim."

4. THE CHILD HIMSELF:

It has been noted that in battering families, one child is usually singled out for abuse. The child is perceived as being "different" by his parents. The use of the word "different" seems to be difficult for protective service workers to understand when confronted with abuse cases. Indeed, the child may be "different;" he may be the wrong sex, the wrong color, fathered by the wrong man, mentally retarded, minimally brain injured, etc. He may be the "symbolic" child. The child who is not the natural child of one of the parents serves as a constant symbol of a previous sexual relationship. The child's personality or physical characteristics may symbolize for the abusive parent an aspect of himself or another person which is threatening or distasteful to him.

> Timmy, a 15 month old Black/Anglo boy, was battered by his Chicano stepfather on numerous occasions. Timmy was born prior to the marriage of his Anglo mother. Timmy's stepfather was able to be a nurturing, capable father to his natural children. The man's rejection of Timmy was so complete that he refused to be seen in public with the boy.

Rejection often begins during the pregnancy or during the neonatal period of life. Protective service workers need to explore the parent's feelings about the pregnancy, the physical condition ofthe mother during the pregnancy and others, labor, and child birth. It is frequently noted that the abused child was premature and spent weeks or months in a hospital nursery. Early bonding between mother and infant does not take place.

The child may present feeding difficulties as an infant. He may be less responsibe to being held than his siblings. The parent often feels that something is wrong ivth the child.

Rejection may be so pronounced that the family reveals the child has always lived with relatives. The relationship between parent and child may never have been established. Abuse often occurs when the child comes into the home for the first time or after a prolonged absence.

> Mark is a handsome, friendly 4-year-old who is permanently brain injured as the result of a beating. His body is covered by old scars sustained during the three months he lived with his parents. Prior to living with his parents, Mark had always lived with his grandmother.

It is impossible to describe the personality or affect of a "typical" battered child, or the way the child relates to the parents. Some children respond to abuse by becoming withdrawn and depressed; they do not smile, neither do they cry. Other children respond by becoming aggressive and combative; they act out their anger at parental maltreatment by destructive behavior. Some children show signs of fear of their parents; others respond affectionately to them.

Because of the many different responses of the children, it is important that the caseworker assess other factors rather than relying solely on parent-child interaction.

5. THE CRISIS OR CHANGE:

Family crises do not cause abuse, but can be precipitating factors. The stressful event may be a major or minor problem that sets the parent off. It may be precise and easy to identify such as a job loss. It may be the crisis of change.

In examining histories of abusive parents, recent change in family constellations, social or economic circumstances are noted. The worker needs to explore recent changes in the family such as pregnancy, new adult family member, new baby or child, or loss of a family member through death, divorce, incarceration, etc. The worker should also be attuned to recent moves to a new location, which may increase isolation.

Job losses, financial setbacks, illness and marital conflict can be factors that precipitate the abuse.

> Tony, a 2 month old American Indian baby, was referred after he had sustained massive brain injuries. His 18 year old mother later revealed that she had injured the child. The family had recently moved form a reservation to an urban community. Within the extended family unit, she had done a good job of mothering her elder child; but confronted with the isolation she found in the city, she attacked her infant.

Changes in the child himself as he moves through various developmental stages can precipitate abuse. The mother whose needs were met by cuddling her infant, may feel that the assertiveness of the toddler is a rejection of her.

6. INJURIES AS DIAGNOSTIC TOOLS FOR WORKERS:

While a medical examination is absolutely essential in making the diagnosis of child abuse, the protective service worker often questions whether the child could have sustained the injury in the manner described by the parents. The doctor may agree that the possibility exists; at that point the worker is faced with a quandary. The following guidelines are certainly not foolproof but have been helpful to many workers.

A. Be alert to accompanying bruises on a child who has sustained more serious injuries. The bruises are often remote from the site of the more serious injury. For instance, a child suffering from intra-cranial trauma caused by "whiplash" syndrome often has small round bruises on his rib-cage; these are strong indicators that someone has shaken the child violently.

B. Evidence of trauma to the head or abdomen is especially serious. Bruises on the head of an infant may not be physically serious but may indicate a great deal of future danger to the child without intervention. Most children who die from abuse, die from head or internal injuries.

C. Children who are burned in the genital area, buttocks, and/or lower extremities are often victims of abuse. Be particularly attentive to accompanying bruises in these situations. The child is usually placed in hot water, had hot water poured on him, or is held under running water after he has wet or soiled himself. The parents usually explain the injury by saing that the child climbed into a tub of hot water or turned on the hot water while bathing. The worker needs to observe the pattern of the burns and imagine the position the child would have been in to have received them in the particular locations, if he has any doubts.

D. Fractures in various stages of healing are almost always indicative of abuse. The one exception is the child who has a bone disorder which can be medically diagnosed.

E. Parents' explanations are usually lacking in detail. They are vague or totally inconsistent with the injury itself. Often, parents attribute the injury to being cuased by the child himself. Head injuries are explained as the result of the child's banging his head; broken legs are the result of the child twisting his leg through the slats of the crib.

F. A delay in seeking medical treatment for the child often occurs in abuse cases. It is quite common for the child to be brought to the emergency room at night. The parent may seek treatment for symptoms other than the injury; for instance, one mother whose child had eight fractures brought him to the emergency room for diarrhea.

7. THE DECISION TO REMOVE:

When a child sustains serious injuries that are inadequately explained and other factors indicating abuse are present, the decision to remove the child at least temporarily must be considered. While no absolute guidelines can be established, two major criteria emerge:

A. When the child has been the victim of multiple episodes of abuse of a serious nature, removal is indicated.

B. When the child has sustained a severe injury for which the parents' explanations are inadequate, removal is indicated.

It is important for workers to remember that the younger the child, the greater the danger. Most children who are killed or who sustain permanent injury are under four years of age.

For a child to be safe in his own home, it is critical that the parent recognize his abusive tendencies, take responsibility for his behavior, be able to reach out for help when he is feeling stress, have a support system available to him at all times, and develop realistic expectations and affection for the child.

Battering parents who injure their children are usually overwhelmed with feelings of guilt and inadequacy. If the parent is unable to drain the guilt and anxiety away, it remains to fester inside until it erupts in another attack on the child. They need to talk about the

experience with a nonjudgemental, accepting person. The cahtarsis the parent experiences is felt as relief and release from pain. It is imperative that caseworkers help parents get through this painful experience. In order to do so, the worker must genuinely care about parents as well as children, and be comfortable enough with himself to be able to permit the parent to spew forth the horror inside him.

One of the major pitfalls for protective service workers is their own denial and its resultant failure to permit the parent to talk about the problem. The worker may be so uncomfortable with facing serious injuries and the fact that a parent has inflicted them that he blocks all attempts of the parent to talk about them. This situation often happens when the parent is a fragile, pathetic person who has suffered much pain in her life. The worker becomes so fearful of inflicting more pain that he retreats and fails to pursue anxiety producing material. The worker may provide the parent with excuses for the child's injuries in his attempt to avoid his own discomfort.

> Mark was 2 months old when he was first referred by the hospital emergency room. The baby had bruised eyelids and small circular bruises on his rib cage. Mark's mother, 17 year old Mrs. M., explained the child had gotten caught between the mattress and the headboard of his bed causing the bruised eyelids. Mrs. M. was a passive, insecure young girl was was very eager to please the worker. The worker perceived the mother as non-abusive but lacking in child care skills. She suggested to the mother that the bruises on the baby's body were probably inflicted when the mother tickled him too rough in play. She spent time teaching the mother about child rearing techniques but failed to help the mother deal with her feelings of frustration. Four months after the case was closed, Mark was once again referred by the hospital. This time he had a skull fracture, broken arm and broken leg, all in various stages of healing. Mrs. M. promptly offered excuses for all the injuries. An experienced worker confronted her with her belief that the child had been battered and wondered what was creating so much strain for the mother. The worker encouraged Mrs. M. to release her pain; that it would hurt to talk about it, but that she believed she could help Mrs. M. Mrs. M. sobbed our her story of loneliness and her feelings of rejection by her mother and mother-in-law. She related that when under stress, she beat her baby. The story was told while tightly clutching the worker's hands. At the end of the interview, she smiled tearfully and told the worker, "I've needed to talk about this for a long time."

A second pitfall occurs when the worker identifies so closely with the injured child that his hostility toward the parents is readily apparent. He assumes the role of interrogator and so threatens the parents that they are unable to share their problems with him.

If parents are to be helped, it is essential that they experience a nurturing, caring relationship with someone they can trust. They must feel accepted as they are, and yet feel that limits on their inappropriate behaviors are present. Help must be available whenever it is needed. Isolation must be relieved; outside support systems are absolutely necessary. Concrete services may be needed, but they are only one small part of the treatment plan. When services are limited to a superficial provision of

resources without dealing with the intra-psychic and interpersonal problems that are at the root of the abuse; abuse will recur.

If the required level of service cannot be provided in a community, or if the parent is unable or unwilling to use help, removal may need to be permanent.

8. SADISTIC-PSYCHOTIC ABUSE:

Permanent removal is required when children are victims of injuries that are deliberate and torturous in nature, or reflect an intent to harm or kill the child. An attempt to permit these children to remain in their homes or return them after placement can only be described as foolhardy.

One element to consider in making this diagnosis is the kinds of injuries the child has received. This diagnosis must be considered when the child has adult sized human bite marks, cigarette burns, puncture wounds, evidence of being stuck with needles and pins, severe malnutrition accompanied by other injuries, has been shot, hanged or stabbed, or has bizarre burn patterns. These injuries are not in the realm of overzealous physical punishment; they can by no means be connected to misbehavior on the child's part. They are far too deliberate to reflect the loss of control present in battering parents.

The parents may reveal bizarre thinking about the child such as his being possessed by demons. He may describe the child as evil.

These situations are much rarer than thos previously described in the sections on excessive physical punishing and child battering. While this parent may present similar characteristics encountered in the battering parent, the worker must not become so convinced of his omnipotence as a helper, that he risks a child's life to boost his own ego. A child who is allowed to remain in an environment producing this kind of abuse is a child who is receiving a death sentence.

CONCLUSIONS

Material has been presented addressing early diagnosis of the severity of abuse as a tool in case management for protective service workers. Major categories of types of physical abuse cases referred to protective service agencies have been described, with critical points for evaluation for diagnostic purposes. Issues regarding necessary removal and avoidance of inappropriate removal of children have been addressed. Case illustrations have been used to exemplify concepts set forth in this article.

While no system is without failure or is completely foolproof, this methodology has been utilized for case management in the Child Abuse Project of the Dallas County Child Welfare Unit for the past three years. Approximately 2,000 children have been served during this period with a recurrence of abuse of less than two percent. The material is presented in hopes that it will be helpful to other protective service workers in their efforts to combat the problems of child abuse.

PART II
INTERVIEWING

SELF AWARENESS IN COMMUNICATION
AND INTERVIEWING CLIENT SYSTEMS

Questions to ask yourself when working with clients

What emotions or attitudes do you seem to have difficulty expressing?

What have you tried to overcome these difficulties?

What emotions or attitudes are easy for you to express?

Which emotions or attitudes do you have difficulty identifying when expressed by someone else?

Which ones are easy for you to identify?

What effective non-verbal attending behavior do you have difficulty expressing?

Can you communicate your interest in another person?

Do you come across as a person who can be helpful?

Can you correctly mirror the content of the other's statement?

Can you "hear" the feelings expressed along with the content? Can you respond to those?

Are you able to time your leading responses (influencing, advice giving, questioning) from your perception, what aspects of your verbal response behavior are of poor quality?

Are you free to respond with your personal reaction (feelings rather than belief or thought) to client system's expression, behavior or attitude?

Are you free to express the reasons behind your personal reactions?

Are you able to judge when these are appropriate?

Do you tend to categorize people?

Do you tend to have similar reactions or feelings toward most people?

Do you criticize quickly - or feel critical?

Do you minimize or universalize problems of others in an attempt to make them feel better?

Do you feel a need to offer immediate solutions?

Do you tend to shy away from distressing problems?

Do you feel a need to shy away from expressed feelings which are troublesome to you?

WORKER BEHAVIORS WHICH INVITE ATTACK	WORKER BEHAVIORS WHICH DISCOURAGE ATTACK
Posture conveys timidness and gives the message that one can be intimidated. Speaks in a soft, halting voice and conveys lack of certainty as to why he is there.	Speaks in a firm, well modulated voice. Has reason for intervention clearly in mind, and states the reason in a straightforward manner. Maintains neutral posture.
Communicates role confustion. Acts as "friendly visitor," "unwilling participant" (I have to do this; my supervisor sent me.), or "police interrogator."	Understands and states his right to intervene. Knows what information he needs and asks for it. Makes requests for clarification in a non-threatening way.
Is inattentive to what is actually happening. Ignores danger signals such as: house shows signs of violence; open bottles of beer/alcohol; erratic or agressive client behaviors; overt threats.	Picks up clues by knowing what to observe and being constantly aware of what is going on. Is sensitive to both feelings and behaviors. Asks client to repeat his understanding of what worker says in order to avoid distortions. If client is under influence of drugs or alcohol, he says so, and states that there is no purpose in communicating under these circumstances. Makes another appointment.
Demonstrates "pushy" posture which conveys a personal vendetta and stimulates defensiveness in client. Uses belligerent language and gestures. Responds to threats with counter threats.	Maintains disciplined awareness of own feelings. Depersonalizes client statements. Is empathetic. Reflects client's feelings. Conveys assertive "I" messages. Allows client physical distance. If threat is made in vague terms, asks client to be explicit. Explores consequences of threatened behavior with client. Does not become angry when personal remarks are made by client.

Developed by Jim Graham, Special Operations Supervisor, Texas Office of Investigators General; Joanne Stamos, Staff Development Specialist, TDHR Region 06; and Kay Love, Program Specialist, TDHR Protective Services for Children Branch.

Self Awareness and Dealing with Hostility

Self-awareness and discipline are essential in the development of assessment and interviewing skills. The professional relationship requires the worker to manage his/her own feelings as well as those of the client. Some of the clients who become involved in the child welfare system respond with hostility or anger when the agency intervenes. It is important that the worker utilize knowledge and skills in handling the angry, threatened or hostile client.

There are many areas in which both workers and clients feel threatened. While any number of factors may be related to these reactions it is important that the worker 1) have the ability to identify and differentiate reactions; 2) be aware of how he/she handles conflict, anger, and negative feedback and 3) posses intervention management, and coping skills in dealing iwth their own feelings and the feelings expressed by clients. The following are pointers to keep in mind when dealing with the hostile or angry client.

Suggestions for Dealing with Hostility

- Be fully aware of the assigned worker role and purpose (investigation of abuse and neglect, foster home assessment, family service interview, etc). Clarity of purpose facilitates the worker's ability to explain fully to the client the nature of the contact and what expectations the worker brings to the situation. Avoidance of this heightens the client's anxiety and may increase hostility.

- Clearly identify yourself, the agency and which division of the agency you represent. Written identification of yourself and your agency should be readily available.

- Share with the client your reason for interviewing without apologizing or minimizing your purpose.

- Inform the client of agency policy and proceudre with flexibility and interpretation. Policy should not be the only method of communicating especially when the client feels threatened.

- Recognize factors involved in the client's reaction to crisis situation such as: 1) disorganized thinking; 2) lack of effective functioning; 3) hostility and maintaining emotional distance; 4) impulsivity, and 5) dependence.

- Recognize when intervention by police or court authority may be necessary.

- Be aware of cross cultural differences in terms of ehtnic origin, social setting and economic status. Clients may become defensive when they feel the worker does not understand his/her circumstances because of basic differences in individuals.

- Be aware of your own personal use of agency authority. A sowker who presents in an authoritarian, controlling manner may be met with hostility due to the worker's behavior and how he/she uses themselves in the situation.

- Anger and hostility may be expressed non-verbally by refusal to respond to questions or withdrawal. This may be a method of showing anger to the worker.

BASIC INTERVIEWING TECHNIQUES

I. NON-DIRECTIVE TECHNIQUES

Although non-directive techniques are less often used as the principal interviwing technique in child protective services than they are in other kinds of social work interviewing, the CPS worker should be aware of them and should use them effectively. Non-directive techniques include head nods, smiles, frowns, eye contact, and body posture/gestures indicating that the listener is responsive to what the speaker is saying. They include verbal minimal encouragers such as "yes", "I understand", "I see", "um", "hum", etc. They may also include verbal follows. In verbal follows, the listener simply repeats a key work that the speaker has used in a statement to demonstrate attentiveness. Verbal follows may also be directive if the work is repeated in a questioning tone, indicating that the listener wants clarification in that particular area. Verbal follows may be used to get the speaker back on track. They may steer the speaker in the direction the listener wanst him/her to go.

Non-directive techniques can be powerful means of expressing empathy. They tell the speaker that the listener is tuned into the speaker's feelings and concerns. The skilled use of non-directive techniques, combined with the more directive, assertive interviewing techniques conveys positive regard even when facing a client with unpleasant truths.

II. DIRECTIVE TECHNIQUES

Particularly in working with involuntary clients, CPS workers must assume responsibility for the direction of the interview. Abusive and neglecting parents generally would prefer not to talk about the reason for the caseworker's intervention. This is expecially true in early contacts. Once rapport is established, parents may talk more freely in giving social histories and in talking about what they want for themselves and their children. Even in working with adoptive parents and foster parents, it is frequently necessary for the child placement worker to probe, confront and deal with verbal assaults on himself/herself and the agency.

Directive techniques include:

A. Assertive interviewing techniques

It is important that CPS workers not confuse assertive interviewing with aggressive interviewing. In assertive interviewing the caseworker acts with authority. In aggressive interviewing the caseworker acts with authoritarianism. The first is from a non-defensive stance. Assertive interviewing in CPS implies an understanding of one's right to intervene in family dynamics in order to protect a child. It also assumes a respect for the parent of the child as a worthwhile individual whose concerns will be listened to but whose actions, in regard to treatment of the child, must change.

Assertive techniques discussed here include:

1. Active listening: It is important that the caseworker focus on what the client is saying. The worker listens to the client rather than focusing on concerns about how she/he, the caseworker, will respond. To let

the client know the worker is listening, from time to time, the worker states in her/his own words what she/he thinks she/he has heard. This technique is called reflection of content. For example:

Mother: Mary is my problem. She isn't as grown up as she wants you to think. She's got a mind of her own and does she know it! She thinks she has the answer to everything. If I make a suggestion she always finds some reason it won't work.

Worker: Mary won't follow your suggestions.

OR

Mary: Everything I do around her is wrong. My mother nags, nags, nags. Nothing ever works. It's all my fault.

Worker: Your mother constantly finds fault with what you do.

Another technique is the reflection of feeling in what is stated. The workers response to the mother might have been:

Worker: You are frustrated because Mary won't follow your suggestions.

OR To Mary

Worker: You are angry because your mother constantly finds fault with what you do.

Reflection is especially helpful in trust building. If the worker accurately reflects what the client has said, the message is conveyed that what was said was important. If the reflection is not what the client really meant, he/she has been given the opportunity to clarify for the worker. The worker has trusted the client enough to risk being wrong in stating his/her perceptions.

Reflection skills are especially valuable at the beignning of an interaction because they are trust building. They are also helpful when the speaker is angry or defensive. Reflection tells the client that the worker knows her/his point of view but he/she knows what it is or is willing to clarify what it is.

2. Fogging. Fogging is a communication skill utilized by workers in a personal verbal attack on them. Fogging was first described by Dr. Manuel J. Smith in When I Say No, I Feel Guilty. It is called "fogging" because attacks, such as verbal rock throwing, do not damage the listener any more than real rock throwing damages a bank of fog. The speaker soon sees this and quits expending energy in verbal rocks. This frees the conversation for more productive areas.

Fogging reduces the listener's defensive responses to attacks. Defensive responses escalate anger and non-productive verbal interchanges.

Fogging can be used in three different ways:

a. Agree with any truth in the ciritical statements of others.

Client: All you do is talk, talk, talk.
Worker: I do talk a lot. OR I could talk less.

b. Agree with any possible truth.

Client: If you paid attention to what I've been trying to say, you'd know what I mean.
Worker: That may be true, I could pay closer attention.

c. Agree with the general truth when speakers try manipulation with logical statements.

Client: You're just like all the rest of the government workers, butting into a family's home life.
Worker: I am a public employee, and a typical one.
OR
It makes sense that public employees are similar in many ways.

It is useful to follow a fogging response with a request or question that will get the conversation back on track.

Worker: It makes sense that public employees are similar in many ways. Tell me how Betty has been doing since she was enrolled in day care.

3. Confrontation: In child protective services, the worker must be a skilled confronter. Confrontation is, basically, facing the clients with the facts in the situation and with the probable consequences of behaviors.

Client: The doctor is telling lies about me. I didn't hurt Angie, she fell downstairs. She is always having accidents.

Worker: I understand that children have accidents. Angie's injuries could not have been the result of a fall down stairs. There are two partially healed fractures in addition to the new head injury. Angie's buttocks and back are marked with bruises in the shape of a hand.

Client: I know we haven't been to counseling in three weeks. Get off my back! My husband and I have other things to do.

Worker: Going to counseling regularly is a part of your agreement with us to regain conservatorship of the children. If the agreement is not followed we can't recommend that the children come home.

Or, confrontation may be tempered with reflection which puts the client less on the defensive.

Worker: I know it is difficult to get into counseling. However, getting there is necessary if we are to recommend return of the children in our agreed time limit.

B. Questioning Techniques

Asking questions effectively is an essential skill in child protective services interviewing. There are two general types of questions. Closed-ended questions are those that can be answered with "yes", "no" or a brief word or phrase. They are used to structure conversation and to get to the point quickly.

Worker: Who was there when Angie fell?
Client: No one.
Worker: Where were you at the time?
Client: In the kitchen.
Worker: Did you hear her fall?
Client: yes.

Open-ended questions encourage discussion and give the answerer freer range to come up with information than in a closed-ended question.

Worker: What did you do when you heard Angie fall?
Client: (generally feels obligated to describe a series of behaviors)
Worker: How do you see the situation now?
OR
What would you like to do at this point?

Probing questions may be either open or closed-ended. They are questions designed to clarify facts. They ask the reporters' questions: who, when, what, where, and how.

Client: She had those bruises on her when she came home from school.
Worker: When was that?
Client: Thursday evening.
Worker: What did you say when you saw the bruises?
Client: I didn't say anything.
Worker: Who else saw her come home in that condition?

Questions are often used in non-productive ways in interviews. Workers need to be aware of some habitual ways of using questions that can be threatening, devaluing, or apologetic. For example:

Don't you think you'd better stick to the agreement? (Or else!)

Why don't you follow through as you agreed? (You're inadequate)

Let's review the agreement. How about it? (I'll back down, if you insist.)

Avoid: Is that O.K.? Why don't we _____? Do you agree? Do you mind telling me _____? Would you like to know why _____? Why did you _____?

"Why" questions are among the most provoking of defensive responses. They imply an attack by insisting on a defense of some action.

* Taken from Basic Job Skills Training Child Welfare Services: Trainees Course-book Texas Ddpartment of Human Resources, Protective Services for Children Branch and Staff Development.

SOME SUGGESTED RESPONSES TO COMMONLY MADE REMARKS AND QUESTIONS

CLIENT	YOU
You have no right be he here.	Mr. (or Ms.) Jones, I am required by law to be here.
Who told you we abuse our kids?	I am not permitted to say who reported this abuse.
Are you going to take my kids away?	I don't know yet. Hopefully, it won't be required. I'm more interested in helping the family stay togehter, healthily and happily.
Get the ____ away from my door, you _____.	It's important that I see you now. Otherwise, I will have to return with the police.
We used to hit Johnny, but we don't any more (or we won't again).	I'm glad to hear that. However, I am required to visit the home and get an updated report.
All you want to do is take my kid.	My job is to do everything I can to help you, not to split up the family.
I never touched the kid.	Perhaps not, but we are required to visit the home and get a report.
It's my husband, and I don't dare say anything, or he'll beat ME up.	I appreciate the position you're afraid and under stress. Can we discuss this more inside?
He only does it when he's drunk.	That's often the case. Perhaps we can work together to find some way to deal with the drinking problem.
The kid made me do it.	Kids can be overwhelming sometimes, can't they? Maybe we can discuss it more inside and see what we might be able to do to prevent it from happening again.
I bet it was that _____ nosy neighbor of mine!	I know that concerns you, but the law does not allow me to tell you that.
I don't know what you're talking about. Somebody's just trying to get us in trouble.	I'm still required by law to make this visit and turn in a report from you. If nothing is going on the report will say so, and we won't have to visit you again.

INTERVIEWING AND WORKING WITH CHILDREN
FLEXIBLE GUIDELINES

1. Ordinarily speak in a calm, quiet voice. Making your voice even softer may get a child's attention.
2. Speak clearly. One of our goals is to provide the opportunity for language learning.
3. Always respect a child. Do not laugh at him or exploit him by using good, bad, size, age, etc. Do not foster competition. (We have all perhaps come to oppress unknowingly and subtly children much as we have oppressed women. Children are as sensitive to oppression and derision as are we.
4. When praising, "reprimanding, or "Feeding Back" be specific about what you are referring to. E.g., "I like the structure you have built with toothpicks" rather than "I like that" or "I like what you did."
5. Use when possible positive rather than negative suggestions or choices; i.e., set the limits of choice within what <u>is</u> acceptable. E.g., "John, you may put the blocks away now with the other children, or you put the blocks away which we leave you to put away by yourself."
6. Answer children's questions honestly and correctly, or way, e.g., "I don't know, we'll try to find out" or "I would rather not answer that because..."
7. When working with the children get on their level; sit or squat.
8. Speak to the children directly by <u>name</u> whenever possible. E.g., "Oh, you're going to the language center where Sandy, Eloise, and Katie are playing," rather than "You're going over there now."
9. Your role play may be to guide and add materials and become involved as a participant in play; or it may be to "direct" the play.
10. When possible, encourage a child to complete tasks alone or with the aid of other children (e.g., shoe tying) to the limit of their capabilities. This so he may grow in independence and be aware of interdependence with peers.
11. Avoid saying "okay" at the end of every request. It seems to imply that you have presented a directive which need not be followed, that is that the choice is between doing and not doing rather than between doing in one way (or at one time or doing in another way). E.g., say "We can go outside after we have all gathered on the rug" rather than "We can go outside after we have gathered on the rug, okay?"
12. <u>Do not</u> suggest a choice when no choice exists, or when you are unwilling to accept one of the choices offered. Therefore, offer (or verbalize) choices between or among alternatives all or which you <u>will</u> accept.

INTERVIEWING AND PRACTICE TECHNIQUES

There are a variety of interviewing techniques the child welfare worker may use in the development of a supportive working relationship with the client. These techniques include:

- Focusing
- Partialization
- Universalization
- Recognition of difference
- Acceptance
- Education
- Logical discussion
- Relating to affect
- Demonstrating behavior
- Setting realistic limits
- Ventilation
- Direct intervention in environment
- Summarization
- Confrontation

Focusing. The worker should maintain the focus of the interview at all times with a clear understanding of the purpose and ultimate goal. For example, a client who has come in contact with the agency for abuse or neglect of a child may have great difficulty maintaining focus due to high levels of anxiety and fear. It is the workers responsibility to; redirect the subject when necessary, acknowledge the client's anxiety and finally repeat the purpose of the interview.

Partialization. Clients who enter the child welfare system often present multiple problems. They may be confused and/or overwhelmed by the environment their feelings and need to solve or avoid the presenting problems. The worker should assist the client in partializing by (1) setting priorities, what are the most urgent needs of the client and agency; (2) what can be realistically handled within the context of the agency; and (3) how to separate out and deal with one problem at a time.

Universalization. The worker uses this technique to point out that most individuals in the client's situation would have similar reactions. Clients often believe that they are different from most other people. A word of caution - this technique may be misunderstood by the client resulting in his feeling that the worker is minimizing his/her concerns.

Recognition of Difference. The worker and client may be from different socio-economic, cultural, or ethnic backgrounds. It is important to establish that the worker recognizes these differences and will make every attempt to understand the client if the backgrounds are different. This tecnhique may also be used as a method of engaging the client around issues of special concern.

Acceptance. It is important to all people that they feel accepted. Acceptance of the client demonstrates an attitude of receptivity by the worker. It is important that the client feels comfortable enough with the worker to begin to face himself, the problem and the situation that brought the client and agency together.

Education. The sharing of information and provision of new knowledge become important aspects of work with clients especially when external agencies such as court systems, juvenile authorities or collaborating agencies are involved. In order to make informed decision, and contract for goal attainment, the client needs to be given information and facts. Education involves repetition and elaboration on the information in relation to new situations.

Logical Discussion. Organization of interview material to be covered in a given session is the responsibility of the worker. The maintainence of a flow in conversation and the integration of client need and agency purpose are achieved by the use of logical discussion.

Relating to Affect. Relating to affect is a method of engaging the client in the casework relationship and becomes important in specific treatment techniques and processes. The worker may want to explore the affect, i.e., "You seem depressed today." or acknowledge and accept the affect i.e,, "Your housing problem puts you in a depressing situation." It is appropriate to name specific feelings or accept feelings only if the worker understands the feeling and there is a therapeutic reason for the client becoming aware and working through feelings.

Demonstrating Behavior. The worker should set the tone and expectations of counseling sessions by demonstrating expected behaviors such as openess, listening, and giving direct feedback. The worker may serve as a role model to a parent having difficulties in parenting. How to handle discipline, sharing and play activity with the child can all be readily demonstrated by the worker. A second method of demonstration may be role-playing with the client. If employment is a goal for the client role playing what the client should expect may be useful for developing client skills.

Setting Realistic Limits. It is the worker's role to set the limits on the nature and type contact that will take place in the interview situation. Contracting is one method that clearly states what is expected of each party in the casework relationship. If unrealistic goals or limits are set in the working relationship, the worker runs the risk of building in failure.

Ventilation. The client may come to the relationship with many pent up emotions or reactions to current or previous life situations. Worker should encourage and/or allow the clients non-verbal and verbal expressions of anger, frustration, depression or simply a sharing of information and feelings.

Direct Intervention in the Environment. Modification of the environment may be accomplished by providing concrete services (housing, financial assistance, homemaker, parent aides, medical assistance, job placement, etc.) or assisting in the clients use of available community resources. When the client is overwhelmed by environmental problems often concrete services provide a beginning point for change both in physical surroundings and personal feelings of worth.

Summarization. The process of summarization involves the worker adding up for the client all feelings and facts shared in a given situation. This should be done in a concise, organized and purposeful manner. Summarization should enable the client to see the interrelatedness of fact and feelings; analyze the positive and negative of a situation; develop clarity on the scope and nature of problems and finally to share in the selection of alternative courses of action. The worker summarizes after sufficient exploration of information and sharing has taken place in the interview situation.

Confrontation. The goal of confrontation is to point out inconsistencies and/or contradictions in the client's affect, attitudes, behavior or information given during the interview and casework process. The goal is not for the worker to interpret or otherwise explain what the client means rather to point up the problems with the client's functioning or ability to handle a problem

SOME GUIDELINES FOR GETTING INTO A CASE

1. A "problem" can be seen from at least two angles--the large "social problem" of society, to the problem as the individual victim (our client) feels and experiences it as a person.

2. In casework we are not dealing with large "social problems" as a philosophical entity. We are dealing with the problem as our client feels and experiences it as a person. We are speaking to the "victim" and need to help him in dealint with confession, pain and needs as he experiences them.

3. We need to help the client express to us, (and feel free to do so), his own confusion, depression, anger or need. Beginners usually cut short this phase. Beginners are likely to change the subject, or cut off this expression of the client.

4. We need to respond to the need of our client with warmth, sympathy, concern, and all we know, as the basis for this response.

5. We need to see the "problem" of the client--not as his individual inadequacy, or as "criticism" of him--but as evidence of legitimate need. (Most of us do the best we can.)

6. We need then to think about the need of our client--using all we know--as we think how to fill this need in our professional role. (For example - What does an abusive parent need from us?)

   What does a foster child need from us? What does this "inadequate" mother need from us? But beyond the theory what does this person--as more than a generalization--need from us?

7. It is better to be "thoughtful" than to be in a hurry in deciding on an approach which will really help.

8. Remember that it is not us who has to "solve" this problem in the end--but our client has to "solve his problem" in the end--manage his situation more constructively, etc. It is our job to know our client well enough, and his needs and difficulties that prevent him from handling his situation or "solving his problem" constructively. "Advice" seldoms works. "Confrontation is only occasionally (and selectively) useful. Choice of technique is based on your understanding of your client and his needs.

The Supportive Method-Beginning Work With The Client

The supportive method is a commonly used technique for social work intervention. The following material summarizes aspects important to this process.

A. The Formation of the Professional Relationship

The formation of a working relationship occurs one time in contact with the client system. It is the complex of feelings - interaction between the client, the worker and the surrounding environment. The worker is expected to understand and manage the basic process of the relationship and attempt to be helpful to the client in reaching a mutual solution to the problem(s). It should be the worker's goal that the relationship is comfortable, constructive and realistic. The worker should recognize that achievement of forming a relationship depends on (1) the nature of the problem; (2) the degree of the client's and worker's investment in the solution to the problem; (3) the degree of realistic expectation both by the worker and client; (4) the nature and extent of reality orientation within the relationship and; (5) the worker's understanding of his role in the helping process and on his handling of the relationship. A realistic relationship may at times not be achieved until near the end of the case plan when some resolution of problems has been reached. Several central therapeutic ingredients are needed for the development of a good working relationship as stated by Carkhuff and Truax.*

Genuineness - genuineness implies most basically a direct personal encounter, a meeting on a person-to-person basis without defensiveness or a retreat into facades on rules, and so in this sense an openness to experience.

The distortions in the worker's own personality have influence on capactiy for genuineness.

There is general agreement that the worker should be either free from serious distortions of his own personality, or at least thoroughly understand his own problems and be on guard against projecting them onto the other person. There is no real alternative to genuineness in the therapeutic relationship. Even if he were a skilled, polished actor, it is doubtful that a worker could hide his real feelings from the client. The client may not know why the worker is "phony," but he can easily detect true warmth from phony and insincere "professional warmth." Since the best operational definitions of genuineness revolve around describing its absence, it is clearly not easy to describe or achieve. It involves the very difficult task of being quite intimately acquainted with ourselves as whole, containing both good and bad.

Lowest level of genuineness: worker presents a facade or defends or denies feelings.

High level: worker presents a high level of self-congruence, where the worker is freely and deeply himself.

Does not mean that the worker must overtly express his feelings but only that he does not deny them.

* Traux, Charles B. and Carkhuff, Robert K. Toward Effective Counseling and Psychotherapy: Training and Practice. Chicago, IL: Aldine Publishing Co., 1967.

Sincere not phony, real feelings or being rather than defensiveness.

Non-possessive warmth:

Non-possessive warmth for the client means accepting him as a person with human potentialities.

It involves a non-possessive caring for him as a separate person, and, thus, a willingness to share equally his joys and aspirations or his depressions and failures.

It involves valuing the patient as a person, separate from any evaluation of his behavior or thoughts.

At its highest level unconditional warmth involves a non-possessive caring for the patient as a separate person who is allowed to have his own feelings and experiences; a prizing of the patient for himself regardless of his behavior.

The worker's response to the patient's thoughts or behavior is a search for their meaning or value within the patient rather than disapproval or approval.

Warmth is even more crucial for the therapeutic relationship which centers on the inadequacies; the life failures, and the guilt-ridden feelings and acts of the client.

Accurate Empathy:

Accurate empathy involves more than--
Ability to sense the client's "private world" as if it were his own.
Ability to know what the client means.

Accurate empathy involves both--
The worker's sensitivity to current feeling and
His verbal facility to communicate this understanding in a language attuned to the client's current feelings.

It involves enough understanding of patterns of human feelings and experiences to sense feelings that the client only partially reveals.

High level of accurate empathy:

The worker's remarks fit perfectly with the client's mood and content.
Responses serve to clarify and expand the client's awareness of his own feelings or experiences.
Communicated by language and voice qualities.
The worker's intent concentration upon the client keeps him continuously aware of the client's shifting emotional content so that he can shift his own responses to correct for language or content errors when he temporarily loses touch and is not "with his client."

At low level:
Worker may go off on a tangent of his own or may misinterpret what the patient is feeling.
At very low level, he may be so preoccupied and interested in his own intellectual interpretations that he is scarcely aware of the client's "being."

May be concentrating on intellecutal content rather than on what he "is."

At low level worker may be--
evaluating the client
giving advice
sermonizing
reflecting on his own feelings and experiences

At high level worker is--
listening
understanding
being sensitive

The worker may facilitate or retard the relationship. It is important that the facilitator is one who has had a healthy early environment; is a whole person; sees the world clearly; and can separate the truth from the myths. Wholeness may be achieved through natural early social process or through help from someone else who is whole and able to share this with the client. The effective worker not only offers high levels of facilitative conditions, but commits himself, very deeply to the helping process.

Feelings are always present in both the worker and the client throughout the intake, assessment and intervention process. The feelings each person brings to the situation will be determined by multiple factors. In child welfare two major roles are played by the situation that brings them together and how both the worker and client feel about themselves before the first contact. If the worker is assigned an abuse or neglect investigation for example; levels of feeling and the nature of interaction will be influenced. It is the worker's responsibility to provide leadership and be a role model for what is expected of the client. The complex of feeling and interaction will develop and change during the working process.

The relationship is a two-way exchange between the worker and the client. While the worker should maintain control of the situation at all times some mutual directions should be set. The worker should be aware of any feelings he/she has toward the client not only to aid the assessment process but to gradually learn to discipline reactions and relate appropriately to the client's feelings. Understanding both his/her own and the client's feelings enables the worker to anticipate changes in the client's feelings and reactions, to predict changes and to manage the relationship in a therapeutic manner. Both the worker and the client have conscious and unconscious ways of managing feelings. Each will evaluate the other in an attempt to determine the feelings of the other. The reactions that the worker and client have toward each other may be reality based on the interactions shared in the casework relationship or may be a reflection of earlier experiences with other people of importance in their lives.

The development of a relationship depends both on the client's and the worker's capacity for a relationship. The client's ability to engage in a relationship cannot be evaluated unless the worker is able to relate to the client. This becomes an important factor when the client and worker are from different ethnic or cultural backgrounds. In order to facilitate the casework relationship the worker should (1) explain and demonstrate to the client how they will work together; (2) convey interest; (3) communicate understanding of the situation as knowledge and facts are acquired; (4) convey to the client that the worker and client share responsibility for getting the client the help that he or she needs. It is the worker's responsibility to identify the nature, quality, and intensity of the relationship.

The relationship needed depends on the client's personality and previous relationship experiences.

The supportive method of intervention includes: (1) maintenance of current level of functioning; (2) improvement of level of functioning without a direct attempt to modify clients' methods of personality defense or to produce awareness of behavior motivation; (3) direct change of specific symptoms or: (4) develop coping skills to endure an unchangeable situation.

The supportive methods should be used when: (1) clients problem results from acute and severe external stress in his life situation (situationally disturbed client); (2) client's problem results from the inability to control or deal appropriately and comfortably with impulses; (3) the treatment goals can be achieved by genuine interest and availability of the worker.

The primary techniques used are exploration, support and goal setting within achievable limits. Support should be a growth-producing and sustaining process with the major purpose of (1) enhancing the client's self-esteem; (2) creation of hope leading to motivation; (3) aiding the client in dealing with environmental stress and (4) assisting the client in the integration of agency, societal and personal expectations.

ASSESSMENT AND INTERVIEWING

Training Materials

Audiovisual and Multimedia Packages

EPD Consortium C. Houston, Texas. Selection and Evaluation of Foster Parents, (Synchronized slide-tape show). (Instructional manual). Austin, TX: Distrubution Coordinator, Media Services Dept., Texas Department of Human Resources, 1978. 19 minutes.

These materials are designed to enhance the skills of workers in assessing foster parent applicants for older foster children. They are part of the multi-media package, "The Realities of Adolescent Care: Staff Training." The manual and slide-tape show are intended for joint use. They outline a five-interview study process which enables workers to assess the applicant's communication skills, flexibility and self-awareness.

George Wareen Brown School of Social Work. Assessment and Decision Making I: Basic Questions (Videotape). St. Louis, MO: Washington University, 1976. 30 minutes.

Narrator explains the purpose of assessment. Scenes from two initial interviews are presented, the viewer is asked to make a preliminary assessment in both cases.

George Warren Brown School of Social Work. Assessment and Decision Making II: Personal Approach (Videotape). St. Louis, MO: Washington University, 1976. 20 minutes.

Narrator outlines the three basic areas a worker must examine in making an assessment: environment, parent-child interaction, and client-worker relationship. Three workers describe their own personal approach to these areas.

George Warren Brown School of Social Work. Counseling Skills I, II, III (Videotape). St. Louis, MO: Washington University, 1976. 20, 7, 15 minutes.

Package of video tapes demonstrates basic skills in interviewing and beginning assessment.

George Warren Brown School of Social Work. The Initial Interview (Videotape). St. Louis, MO: Washington University, 1976. 20 minutes.

This videotape is a part of the "Family Service Training Program: Child Abuse." It presents information on worker-client interaction at the initial interview.

Ivey, Allen and Norman Gluckstern. Basic Attending Skills. North Amherst, MA 01059: Microtraining Associates, Inc., P. O. Box 664, 1981.

Multimedia package focusing on effective listening and nonverbal components of the interview including attending behavior, questions, paraphrasing, reflection of feeling, summarization, integration of attending skills and scoring of interfiewing leads.

Ivey, Allen and Norman Gluckstern. Basic Influencing Skills. North Amherst, MA 01059: Microtraining Associates, Inc., P. O. Box 644, 1981.

Multimedia package which assumes basic interviewing competencies, and focuses on the interview as a process of interpersonal influence. Content includes self-expression, directions, self-disclosure, interpretation, direct-mutual communication, self-directed self-expression, integration of skills.

National Institute of Mental Health. Simulated Role Play of Initial Diagnostic Interview with Abusive Parent (Film 16mm, color). 5600 Fischers Lane, Rockville, MD 20852, 1976. 25 minutes.

Demonstrates the social dynamics of the initial diagnostic interview with the abusive parent.

National Institute of Mental Health. Treatment Techniques Sampler (Film, 16mm color). 5600 Fischers Lane, Rockville, MD 20852, 1976. 50 minutes.

Simulated vignettes that give a series of specific treatment techniques shown in brief worker-client interactions.

National Institute of Mental Health. Case Planning and Referral (Synchronized color filmstrip audiocassette). 5600 Fischers Lane, Rockville, MD 20852, 1976, 15 minutes.

The major components of case planning are reviewed from a family and professional point of view. A case history is followed through needs assessment, treatment planning, implementation and referral, and case monitoring. The important differentiation between problems and needs is stressed, along with the need for consultation, case conferencing, and family involvement. Assessment of the agency responsible for treatment is emphasized. The importance of follow-up by the caseworker is also noted.

Regional Institute of Social Welfare Research, Inc. The Case Management Model (Videocassettes and Manuals). Athens, GA 30303: P. O. Box 152, 1977.

Significant content area includes: case management, including evaluation of need, planning for service, service provision, follow-up and case recording.

University of Michigan, School of Social Work, Child Welfare Learning Laboratory. An Assessment Interview With Ruby Haynes (3/4" color videocassette or ½" videotape). Ann Arbor, MI 48103, University of Michigan Television Center, 1975, 22 minutes.

This videocassette is designed for use with the Family Assessment module of the training product, "Child Welfare Learning Laboratory Materials." It illustrates the use of the family assessment interview as outlined in the training course by depicting an interview with a client, Ruby Haynes. The client defines her problem, gives its historical background and tells how she was referred to the agency. The worker and client discuss available resources to assist with problem resolution and decide on the first step to be taken.

University of Michigan, School of Social Work, Child Welfare Learning Laboratory. An Assessment Interview With Sara Smith. (3/4" color videocassette or ½" videotape. University of Michigan Television Center, 400 Fourth St., Ann Arbor, MI 48103, 1975. 27 minutes.

(Abstract continued on following page)

This videocassette is designed for use with the Family Assessment module of the training product, "Child Welfare Learning Laboratory Materials." It depicts a social worker interviewing an 18-year-old unmarried mother, Sara Smith, who allegedly has neglected her child. During the interview, the presenting problem is discussed and family relationships are explored, including the mother-daughter and extended family relationships. The worker and client also look at potential resources for problem resolution.

University of Michigan, School of Social Work Child Welfare Learning Laboratory. Behavior Mangement: As Assessment Interview, (3/4" black and white videocassette or ½" videotape). University of Michigan Television Center, 400 Fourth St., Ann Arbor, MI 48103, 1975. 22 minutes.

This videocassette is designed for use with the Behavior Management module of the training product, "Child Welfare Learning Laboratory Materials." It depicts a social worker interviewing amother and her adolescent daughter around the issue of their strained relationship. The mother uses a behavior assessment interview model and helps the clients define the problem and their feelings associated with it.

University of Michigan, School of Social Work, Child Welfare Learning Laboratory. Behavior Management: A Contracting Interview, (3/4" black and white videocassette or ½" videotape). University of Michigan Television Center, 400 Fourth St., Ann Arbor, MI 48103, 1975. 25 minutes.

This videocassette is designed for use with the Behavior Management module of the training product, "Child Welfare Learning Laboratory Materials." It depicts a social worker assisting her clients to negotiate a behavioral contract. The clients are a mother and her adolescent daughter who have major conflict around the daughter coming home late. The contract negotiated includes a trade-off which allows the daughter increased telephone privileges in exchange for earlier reporting home hours. The tape is a follow-up to the previous reference.

University of Michigan, School of Social Work, Child Welfare Learning Laboratory. Child Welfare Learning Laboratory Materials (Videotape). University of Michigan Television Center, 400 Fourth St., Ann Arbor, MI 48103, 1975.

This multimedia training package, comprised of seven modules, is designed to provide knowledge and skills to line service workers and supervisors in public child and family service agencies. The seven topics covered by the modules include: Family Assessment; Shared Decision Making (between worker and client); Interagency Coordination; Prevention and Work with Natural Helpers (i.e., assisting clients-at-risk through the use of informal and semi-formal helpers): Behavior Management; Staff Development and Training; and Consultation. The modules are organized to allow for flexible training use. They can be used independently or content from various modules can be combined to create a training program to meet specific agency and staff needs.

University of Michigan, School of Social Work, Child Welfare Learning Laboratory. Demonstration Tape, (3/4" Color videocassette or ½" videotape). University of Michigan Televisiion Cneter, 400 Fourth St., Ann Arbor, MI 48103, 1975. 22 minutes.

(Abstract continuted on next page)

This videocassette is designed for use with the Shared Decision-Making module of the training product, Child Welfare Learning Laboratory Materials. It depicts a social worker interviewing a client who is not ready to engage. It illustrates the point that the shared decision-making process is not a viable service approach when the client is not ready to participate.

University of Tennessee, School of Social Work, Nashville Branch. Vantage Point (Multi-media). Knoxville, TN 37196: University of Tennessee Research Corp., Room 404, Andy Holt Tower, 1977.

Seven videotape training modules offer an opportunity to experience social service intervention in its natural setting. The videotapes present a chance to observe real workers interacting with real families. The presentation of these spontaneous episodes is accompanied by worker-supervisor interactions after the client interviews. In addition, well-known consultants comment on the interviews.

Handbooks and Manuals

Borgman, Robert; Edmunds, Margaret; and MacDickens, Robert. Crisis Intervention: A Manual for Child Protective Workers, part of Child Abuse and Neglect USER Manual Series. Publication # (OHDS) 79-30196. Washington, D. C., National Center on Child Abuse and Neglect, Office of Child Development, Children's Bureau, P. O. Box 11820, 1979.

This manual was developed for workers in child abuse and neglect. It consists of three major modules which include: "Overview of Crisis Intervention;" "Assessment of Persons in Crisis and Their Problems;" and "Providing Support in Crisis."

Continuing Education Bureau, Texas Department of Human Resources. Crisis Intervention (Handbook). 5350 Burnet Road, Austin, TX 78756, 1978.

This material is designed to help workers develop interviewing and assessment skills in crisis intervention. The content module is based on Howard Parad's crisis intervention module. It presents the sequence of a crisis situation, identifies the parts and examines case situations in terms of their suitability for the crisis intervention model.

Evans, David; Margaret Hearn; Max Uhlemann, and Allen Ivey. Essential Interviewing: A Programmed Approach to Effective Interviewing. Box 641, North Amherst, MA 01059.

Programmed text to develop better communication skills in face to face situations.

Scott, Robert A. and Houts, Peter S. Individualized Goal Planning With Families in Social Services (workbook). Virginia Department of Welfare, Blair Bldg., 8007 Discovery Drive, Richmond, VA 23288, 1978.

This training manual is designed to provide staff with the necessary information and skills to develop meaningful social service goals and to organize plans to achieve these goals. The workbook is divided into five sections where participants learn techniques on how to help motivate clients to develop, achieve, and maintain meaningful goals through the use of service contracting principles. It provides a brief overview of the basic strategies of goal planning and exercises and writing goal plans. It also includes guidelines and samples for developing goal plans. The manual can be used by trainers to conduct training sessions, or can serve as a self-instructional tool for workers.

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